DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 3

2. STATE: TENNESSEE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☑ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY ~~99/2000~~ $ 0
b. FFY ~~2000/2001~~ $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A page 13c of 13c.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services - Emergency Payment Methodology.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
John D. Ferguson

14. TITLE:
Commissioner

15. DATE SUBMITTED:
June 30, 2000

16. RETURN TO:
Tennessee Department of Finance and Administration
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

Attn: George Woods

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 3, 2000

18. DATE APPROVED:
January 12, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crosser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

EMERGENCY PAYMENT METHODOLOGY

This methodology applies only to services which were formerly covered under the TennCare managed care program. It does not apply to Medicare crossover payments or to other services not covered under managed care.

This methodology will be used only during a designated emergency period that has been mutually agreed upon by the State and HCFA. It will be discontinued at the time that the designated emergency period is determined to have ended.

Acute care inpatient hospital providers will be reimbursed the per diem rate in effect as of December 31, 1993. The rate will be adjusted to include the capital component and eliminate the education and disproportionate share components. There will no longer be a tax component. Payment will be considered to be "reimbursement in full" with no cost settlement. In the event there are new providers since December 31, 1993, for which Medicaid provider numbers have been issued, a rate will be established for them using their most recent cost report submitted to the Office of the Comptroller. The rate will be trended back to December 31, 1993 to be consistent with other hospital providers.

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